First Hill
SURGERY CENTER

Radical or Simple Orchiectomy
Consent Form

Patient Name: _____ Date of Birth: _____

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr._____to perform a **Radical or Simple Orchiectomy** upon me. I understand the procedure is to be performed at First Hill Surgery Center. This has been recommended to me by my physician in order to diagnose and/or treat testicular cancer or other testicular problems.

I understand that the procedure or treatment can be described as follows:
Procedure is performed on an outpatient basis and typically takes less than an hour depending on an individual's anatomy. For a radical orchiectomy an incision is made in the groin region. The testicle and the cord are brought out of the scrotal sac and up to the region of the incision so that the cord can be sewn tight and divided. The specimen is removed and sent to pathologists for further examination. The incision is then closed and a sterile bandage applied.

For a simple orchiectomy an incision is made in the wall of the scrotal sac; the cord structures are tied with sutures and then divided. The specimen is removed and sent to pathologists for further examination. The incision is then closed and a sterile bandage applied.

This procedure may require anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Confirmed diagnosis of testicular cancer, relief from infection and/or pain

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

- Infection, persistence of infection, hematoma, chronic pain, paresthesia (numbness near the scrotum), and excessive blood loss

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4 **TISSUE DISPOSAL/PATHOLOGY**

Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.

5 **MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests such as a partial orchiectomy or observation. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **radical or simple orchiectomy** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ Date: _____ Time: _____

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____